Reinventing Medicaid Children's Initiatives Stakeholder Mtg
September 30, 2015 – 2:30pm
Meeting Minutes

Attendees: Brenda Duhamel, Jason Lyon, Hannah Hakim, Sharon Kiernan, Lauren Lapolla, Beth Bixby, Jessica Paulanski, Christina Ricard, Melissa Linicus, Craig O'Connor, Kevin Nerney, Petra Jackl, Tammy Russo, Tina Spears, Rachel Reichert, Jessica Waugh , Michael Concilliere, Sarah Ostrom, Tinisha Richards, Heather Sargent, Jen Bonneau, Belinda Taylor, Michele Marcello, Janet Marquez, Sandra Pelletier, M Murphy

I. **Welcome –** Brenda Duhamel welcomed the group, reminded everyone to sign in if that has not already been done. Advised the group would be going through a few documents today (available upon request via email).

Two big initiatives in Reinventing Medicaid that impact this area are integrating out of plan services for children with special health care needs into Medicaid Managed Care Organizations. The other is Redesign of CEDARR Services. Today we are discussing updates.

II. **Updates: Including Services for Children with Special Healthcare Needs in the Medicaid Managed Care Benefit.**

We did some outreach with the health plans to determine what they would need to know to have this initiative move forward. We have a date to meet with the health plans by 10/16 with a definite for them of a new scope of services and requirements. Meetings with providers will happen by October 23, and a finalization of standards and formal letters to providers with 60 days notice will be sent out by October 30. In November there will be development of a detailed readiness plan, and continued meetings with plans weekly to complete readiness work and communicate with providers as needed with the goal of making the change by January 1. To be clear, if we need to push back and the work is not ready, we will push back, but our goal is January 1, to do so efficiently and effectively. The standards are not yet ready – from our initial review, and with your feedback already given, there are no changes

Q. Were the changes to the coordinator code to eliminate one code and increase a rate in another code to make up for a majority of that, really established when PASS program was created? Much of that work is now done and in operation, and it felt like a barrier to continue to ask the plans to use that code. We have figured out a way to increase more of the direct service implementation rate.

Q. At the meeting we had some concerns about that, and did not yet have

a chance to follow up to explain that code change to the families. Our concern and tress is what is happening with the proposed changes.

Brenda Duhamel: That is just why we are here to day, so good to know that you are concerned about this. Telling us what those are (this was seconded by the group), allows us to look further at the changes.

Q. It seems like the codes were mixed up on that first document, almost as if they were backwards. The coordinator code or the admin code, would like to weigh in on what is more useful for us.

Brenda Duhamel: We can look at that for certain. It is not just about the money, if you are using the code we need the detail on that.

Q. I agree don't think the definition is really clear, what is being done within the coordination code is vastly different from the admin code. Want to present them with a good plan, we print a lot of things for families to consult and show new techniques and ideas. We should discuss more.

Brenda Duhamel: It sounds like you are doing things that there is not really a pay code there for that, and we need to know those specifics so we can be helpful.

Jason Lyons: The standards came from the extractions review meetings last spring. The feedback morphed into the changes we are looking to carry out.

Brenda Duhamel: Nothing we are holding back, don't want to imply there are secrets, just no additional changes.

Q. Has there been a change from "hours-on age" vs. medical necessity?

Brenda Duhamel: Always based on medical necessity. There is language there that speaks to an authorization for 6-12 hours; this does not mean a family cannot get 20 hours, but would need to back up that there is medical necessity for the 20 hours. We want to be clear to the plans that we want this kind of intensity level.

Jason Lyons: Again, these are standard as we need parameters to work around. Trying to get rid of the "hours" language, and refine it. I think the language may have been updated since the provider meeting, termed it as "standard authorization" with clinical justification more can be prescribed or requested.

Brenda Duhamel: This is why it is important that we oversee the plans,

we need to understand what they are authorizing or not. If there are issues we will move forward.

Q. When you mention clinical justification, do you mean this is what you will get first, and then you can apply? If the initial intake states a reason for an 18 hour treatment, can that be accepted at the outset?

Jason Lyons: As long as there is a reasoning for that treatment at the outset, and it is not arbitrary, that is acceptable. When we look at 12 years of data, the average requested was 18.5 hours, the average delivered was 12.6. We have heard that there are outlying reasons, but that is a significant amount over a twelve year span.

Q. The max hours combined are 25 hours, but what do those look like now?

Brenda Duhamel: Again the word "max" is a word we don't want to use; it depends on what a family needs and what is prescribed appropriately. We can go back and look at the language so that maximum is reviewed and there is standardization. We want the plans to have the flexibility to provide more if they can. We are not trying to set a limit.

Jason Lyons: And also help providers to deploy their staff to reasonable and flexible schedules, so as not trying to put folks who are overworked into situations that are unnecessary.

III. Updates – CEDARR Family Center Redesign Updates

Our timeline on the CEDARRS is to seek family input on care coordination by 10/09, define a new scope of services and requirements by 10/16, meet with providers to discuss these efforts by 10.23, finalize standards and send out a formal letter to providers with a 60 day notice by 10/30, develop a detailed readiness plan by 11/06 and meet with providers as needed for technical assistance and support from 11/6 until complete. RIPIN is having Family Input sessions on Reforms the week of October 6, with dates available on their website.

We may have to think about the name of the centers, and be sure that the name makes sense given the new scope.

Q. This question is on both timelines, the 10/23 to 10/30 to send out a notice, and then to have a formal letter out, I am concerned that is giving folks less than a week to look down and determine if they can fit their program into this future program. While we have been meeting a bit, we

haven't had meetings on the particulars on the CEDARRS scope of services. That doesn't give a significant amount of time to determine capacity to implement. Is there any wiggle room with that time frame?

Brenda Duhamel: Any suggestions? Can we send out the formal letters later, and would that help you?

Response: That would be helpful.

Brenda Duhamel: We could do either way, finalize on the 30th or wait a little longer. Either way you will have the 60 days to determine what you will do next. We can talk offline about the timeline if you prefer, but the sixty days is designed for internal planning at your agencies and groups. We have a meeting with all the CEDARR family centers on the 14th of October. We do know it is a tight timeline, it is on our end too, but want to keep moving forward. Email us with your recommendations.

Q. When you get the feedback, you have the feedback fro insurance, you are going to make more changes to the standards, then send by the 23rd, then will we have a chance to meet with you in that week before they are finalized?

Brenda Duhamel: We could try to meet on the 26th if this conversation needs to be brought on more. We feel we have heard you, but if you want your voice to be heard further, please know you do not have to wait for a formal meeting to do so. Reach out to us.

Brenda Duhamel: As related to these two initiatives, we want to speak a bit about a couple of items that are underway. Our Respite Services modifications and PCMH Kids.

Jason Lyons: Post October 1 families seeking respite in the future would not be required to have CEDARR family services in order to have respite services. When meeting with the providers last week, and following that we have come up with a document of FAQs that have come up. This is available to all in handout form, or via email by reaching out to lauren.lapolla@ohhs.ri.gov. A second handout is a three page document with copies of the letters that went out to the respite providers and respite family members for a survey to determine if the family would like to remain in CEDARR.

Q. Last week there was discussed an idea about reimbursement for the respite policies?

Brenda Duhamel: Have not had a chance to review yet, but it's on the list. If some change in payment methodology were to occur that would

happen by January 1.

Q. Tring to keep the flow, I am still not 100% sure of the steps of the process, respite applications, where to send to the plan, what happens when. Is there an organizational structure, of what and when goes to whom in these processes that we could see?

Brenda Duhamel: Sure.

Q. In that vein, could RIPIN be given a bit of that break down as well, so that we can assist families who call?

Brenda Duhamel: Yes, but of course we would encourage any questions to come into Karen Sullivan in our office.

Q. I see at the end of the FAQ document, I see that Medicaid will continue to maintain the list for respite services? Is that correct?

Brenda Duhamel: From October to January – once it goes in plan then no.

Q. Is the plan to have all three HBTS, PASS and Respite in plan?

Brenda Duhamel: Yes, that is the plan. It is the payment that will be the difference, coming from the MCO side rather than FFS. We are asking the plans to keep our networks of providers, the services will be the same. If you are in managed care it is because you have no other coverage, rather FFS you do. The way things work now, CEDARR played a big role if a family had a concern then they had a CEDARR worker. If a family is not enrolled they could not use the CEDARR worker for the grievance process. Now they will go to the MCO or EOHHS.

Jason Lyons: Initially we would hope that the family would work with the respite provider to deal with the grievance, then to EOHHS.

Q. This is again just Oct – Jan?

Brenda Duhamel: Yes.

Q. When they are approved Oct 1, instead of going to a CEDARR they will go to Karen at EOHHS, who will contact providers for openings in October?

Brenda Duhamel: Yes, and communication will come from EOHHS Oct – Jan.

Hannah Hakim will speak a bit about PCMH Kids.

Hannah Hakim: For anyone who may have missed this, PCMH Kids is a multi payer patience centered medical home initiative. There is a hand out to explain who the practices are that are participating. We are negotiating with the major health plans in RI, wrapping up that contract process, in the requirements of the practice's measurables, deliverables, and expectations on behalf of the practices that they are transforming their care into higher quality care models. The role of the care coordinator, these payments from the health plans will come to help designate staff on care coordination. We have defined what that role is in the contracts with the practices, and leaving up to the practices who fulfills that role. They may look to their patient population and see a group that is best served with a LISCW in this role, or may choose an RN for example. We know that lots of families receive a lot of care coordination from many places, so much of this conversation is how to get families what they need without already duplicating their needs. In that we talk about what re the right needs to trigger care coordination, who to standardize how to assess families to meet their needs, and core competencies or qualifications for what the care coordination needs to have.

One thing we have discussed with the CEDARR family centers and the PCMH Kids practices is potentially putting a CEDARR family center clinician on site at these practices to help serve the highest need families. One idea to consider to help coordinate the care, we see a lot of opportunity to increase that between the practices and the CEDARRS, thus it is an idea we are considered.

Q. Is there a proposed date to have a care coordinator hired by?

Hannah Hakim: About 30 days after the contracts are enacted, and that expected enactment date is Jan 1.

Q. Thanks for the update, in terms of the possible CEDARR co location, I know that some of the CEDARR activities have been at the site of the family homes, not necessarily at a practice, has that been discussed, if they do collocation, can it continue at a home?

Brenda Duhamel: I think you are right, what makes it different than care coordinators that we would have is to go to the home, to go where it is useful. We want to maintain that for families, but we think what may be useful is to have co-located with a pediatric site and be right there, and be in the same group. If at the well visit they can then go to the CEDARR clinician that is great and then see if they need a home visit etc.

Hannah Hakim: We do see that CEDARR has been able to provide things others could not, thus thinking creatively to have practices benefit from

that, hence the idea of co-location.

Brenda Duhamel: In talking about CEDARR we have one more thing to discuss, we do want to discuss an area for input. We see key responsibilities of CEDARR services to conduct outreach, to do an assessment of needs, to develop and implement coordinated plan of care, to assist families with system navigation and advocacy, to facilitate transitions of care and to provide brief therapeutic interventions/clinical consultation. Proposed changes that are considering are: to make it optional rather than required. That it would be for shorter term rather than long term. And also the service authorization function, and shifting it over to the managed care plans and the state agency. We do want to use this opportunity for feedback.

Comment: I have concerns over the optional vs. required. From the provider perspective, there are a lot of families that we work with that do not think they need it, but they do. On the clinical side we see they can use CEDARR and it be better for the patient. I fear that by putting it entirely in the family's lap, we may be the bearer of bad news, that we may be put in a sticky situation. If the provider can say in order for us to provide you with the services you deserve you need A, B, and C that would be better.

Brenda Duhamel: To some degree we see that as: if it is an unsafe situation, we do need to think about that. As part of an authorization that may need to be worked in, i.e. cannot get respite services if the family situation is unsafe.

Q. Yes absolutely but who is going to help get them to safe, as an HBTS provider that is not my role?

Jason Lyons: Right, but as a provider you can just suggest that they go to a CEDARR.

Brenda Duhamel: If they have a higher level of need than what you offer, then it is on the care coordinators who are a part of these redesign to get involved and help to bring those needs into the correct line of service access.

Q. While it would be that they get the referral at the pediatric office to the service that they thought they may need, if the family wants a less intensive service, but a clinical intake shows they need something more, that is where we have used CEDARRS. We have had families who say we want PASS we don't want ABA, but we are stuck saying that is not clinically appropriate.

Brenda Duhamel: If it is not clinically appropriate, then that is the road

you follow.

Jason Lyons: The service still has to be authorized by the payer. Before it is authorized they will receive the materials to determine if the child or family meet the criteria. It won't be just the family desires, it will be that AND the level of care criteria.

Q. As of Jan 1 under the way we envision it, families will literally show up at the door, to call directly and say I need say HBTS. There will not be that gatekeeper which CEDARRS have done, that will be gone overall.

Q. And it is happening in commercial insurance now, I almost feel if going through CEDARR was required initially and then this family.

Brenda Duhamel: We get that. But we don't believe it is right to force families to go through a CEDARR. We do hear you that if a family goes to you and they don't want the right service, that onus is now on you to explain that, and they may not be right.

Q. Right, and concerned that if I don't take you, then you will be left out on your own if you will not take the services we say are correct.

Q. I am hearing what sometimes some of our staff see DCYF as a leverage, use it as a clinical need to help guide the families. It is the families and us, so I think at the time of the screening process linking them to an appropriate service is key.

Q. I would feel better if we heard when this happens, this is the road you would take to resolve it. Also, what happens with the families we have now that the provider feels are benefitting from a CEDARR, then what is the provider role in that?

Jason Lyons: The thing that concerns me is that we are tip toeing down the line of knowing what is better for the family than they know what is best for them, and I feel that is a slippery slope.

Brenda Duhamel: That is why care coordination is so important. They need to figure out what the right avenue is, and help families determine how to meet their needs.

Q. If they family comes from a PCP to an agency they would almost have a pre auth for the service. If someone comes knocking on the door is their a prior auth, or do we have a plan?

Comment: The family should have the choice, the level of services with guiding needs from pediatricians, from psych, and the providers who

have these types of services should be screening and providing and if the needs cannot be met by that provider, then the referral is made to the correct area. With CNAs and Nursing agencies they do that now, they come out, and assess the child.

Jason Lyons: They went out and did the assessment and if they do not have the right service to provide they were still paid for the assessment?

Q. Yes. Follow up question, if they are self-referred will they come with a script, are they on a wait list, are all the kids on the state wait list let lose?

Brenda Duhamel: We do need to think about that. There is a current wait list that we manage at the state level. The point is if we manage it then as soon as there is an available spot, we can reduce that time. We will need to work collaboratively with the health plans to try to make that wait list go away.

Q. Will self-referrals know who to call?

Jason Lyons: I wanted to ask that, how often will a family call without any knowledge of where to go?

Group: A lot

Jason Lyons: Okay so we need to think about that, on the other side most of the stuff is manageable as people are reaching out, they are asking questions, so now they will work with their health plans.

Comment: I agree, but one of the concerns is that the CEDARR systems have worked wonders for kids in HBTS and PASS programs. There used to be four year wait lists. The numbers of kids looking for these services have outpaced the number of providers, this is a group of kids that have only 12 HBTS places to go to. Concern is not will it happen, but it used to happen.

Brenda Duhamel: We feel that by changing this, by putting them into managed care, then this will continue to help manage those issues. We want these services to be available to all families. In the direct services we have HBTS, PASS, and Respite. The plans have a variety of services in addition that they can offer. We want the plans to think if there is something that can be done in place of these services while the child is waiting.

Q. To follow up, would the family go to the PCP, first get insurance authorization? The PCP will say you are eligible for HBTS so who then connects them before we get the call?

Brenda Duhamel: That is the plan most likely. A lot of this detail will need to be worked out.

Q. Is there any way we can get these standards to wrap our minds around it before you go back to them with feedback? Important pieces like the steps being in the standards would be very key; without seeing them it is hard to know how to help you all iron this out.

Brenda Duhamel: Again, until we really sit with the plans, until they explain to us what they are doing, we don't have much to put in writing yet. We need to meet with them.

Q. I am concerned that they will say give in to us and we cannot give you any input on how to work through the conversations.

Jason Lyons: The operations of the authorizations may differ from NHP to United, so the process may not be in the standards. I think it is interesting that you request more detail, whereas we are trying to give you more latitude to know your clients, to know your business and to get the work done appropriately.

Brenda Duhamel: We do get the message that you need to know what those goals are, what we are doing.

Sharon Kiernan: And we will continue to solicit input from all involved to make the transition as smooth as possible, and we will continue to meet with the plans, to educate members, for it is very important this work out as smoothly as possible. One reason we are doing this is all the input we have received over the past several years.

Q. A big concern we have already addressed, the PASS program will not have coordinator through the elimination of the coordinator code. Do we call it case management, I am stuck on looking the coordination code from PASS.

Brenda Duhamel: We hear you. Thank you.

Q. I think we do need some parameters with the MCOs to say what the process will be for providers and families. While that is a policy thing, I think it is key to work out in advance of the launch.

Jason Lyons: Right, we don't want there to be any barriers.

Q. In terms of capacity of the plans to take on this role – it seems as though much of what you lay out makes sense yet some of the front door

coordination is tricky and dependent on families with knowledge. It is a new navigation point, not through the fault of the plans, but some of the experience around CEDARR coordination may leave a gap. There will need to be boots on the ground from the plans, given the sheer number of people coming at them.

Brenda Duhamel: Absolutely that is why readiness is so important. If for some reason we are not set by Jan 1, then we will wait till Feb 1. Readiness is key.

Q. Also, regarding PCMH Kids, what about the number of practices that are not yet PCMH Kids, will they get there faster by playing this role for families?

Brenda Duhamel: You are right there are many practices in RI who help families with special needs, so it is important to still have CEDARR as well. Just redesigned.

Comment: When we talk about the concerns we hear today, maybe it makes sense to think about having the initial referral still come from the CEDARRS, going through the check list, then once they are at the provider then they are no longer required to be enrolled with the CEDARRS. They hold the initial role, but their role can be done once the direct service piece is moved about.

Q. When we send our plans to CEDARR they review all of them. Now if we send them somewhere else, they only review a small percentage of them?

Brenda Duhamel: We need to figure out the FFS side, yes.

Q. That is a concern if only 5% of the plans or 10% of the plans are being reviewed for authorization.

Brenda Duhamel: We need to look at what we are doing on the FFS side, it is a detail we are looking at.

Q. To me it feels like a double check.

Brenda Duhamel: The plan review is about payment, if NHP is going to pay it they will review before paying. The kids who are FFS that is EOHHS decision, in the past CEDARRS have done that, and as a part of this redesign we take it back. We are working out the details for that review. That is separate from the managed care side.

Jason Lyons: The way we see the review of claims in the future is quality measures, not authorization of services. This is us taking samples of

those plans.

Q. Right now we have standard documentation of plans. Will the plans require their own documentation? Will it be standardized?

Brenda Duhamel: We need to work with the plans on that – we want as much standardization as possible understanding that that some things may not be completely possible.

IV. Public Comment – No additional comment offered by the public at this time.

V. Adjourn